STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 122098-001**

Priority Health HMO
Respondent

Issued and entered
this 22nd day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 29, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. Petitioner receives health care benefits under a plan administered by Priority Health, a health maintenance organization.

Priority Health was notified of the request for external review and furnished the information used in making its final adverse determination on June 30, 2011. After a preliminary review of the material submitted, the Commissioner accepted the request for external review on July 6, 2011. Priority Health provided additional information on July 14, 2011.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the Priority Health "Point of Service" certificate of coverage (the certificate). The Point of Service plan has two levels of coverage: "Preferred Benefits" coverage for medical care received from Priority Health participating

providers and "Alternate Benefits" coverage for care from non-participating providers. In general, deductibles and copayments are lower for members under Preferred Benefits coverage. In addition, Preferred Benefits coverage has more favorable out-of-pocket maximums and benefit limits.

The Petitioner is a 54 year-old male who received medical care at the XXXXX in XXXXX on March 21 and 22, 2011, for a cardiac condition. The XXXXX is not a Priority Health participating provider. The Petitioner did not have prior written authorization from Priority Health to be treated at the XXXXX.

Priority Health provided coverage for this treatment under the Alternate Benefits level of coverage. Priority Health denied Petitioner's request to have the care covered at the Preferred Benefits level of coverage.

The Petitioner appealed Priority Health's decision to process the claims at the Alternate Benefits level. At the conclusion of Priority Health's internal grievance process, the Petitioner received Priority Health's final adverse determination letter dated May 26, 2011.

III. ISSUE

Did Priority Health provide the Petitioner's coverage at the correct benefit level?

IV. ANALYSIS

Petitioner's Argument

Petitioner argues that the treatment he received at the XXXXX should be covered at the Preferred Benefits level because Priority Health did not inform him ahead of time that the services were available in-network. He states by the time Priority Health informed him that there were providers available in-network, he had already seen a physician at the XXXXX and wanted to continue to receive medical care at that facility. Petitioner also states that Preferred Benefits level were applied when he visited the XXXXX a few years ago and, therefore, the same level of benefits should apply in this instance and in the future.

Respondent's Argument

In its final adverse determination of May 26, 2011, Priority Health explained its determination of benefits:

> Uphold denial – requested coverage will not be provided as services are available within the Priority Health Network of Providers. Service with Non-Participating Providers is covered at the Alternate Benefit level when medically appropriate

> treatment is available within the Priority Health Network of Providers in accordance with the Certificate of Coverage.
>
> Although the Appeal Committee understands [Petitioner's] desire to be treated at XXXXX based on positive past experiences he has had there, there are providers with the same expertise in plan. If [Petitioner] would still prefer to be seen at XXXXX, he is able to receive coverage at the Alternate Benefits level as provided by his plan.
>
> Examples of Participating Providers are Michigan Heart, West Michigan Heart, and Spectrum Health Cardiology.

Priority Health contends that its benefit determination was in compliance with the terms of the certificate of coverage.

Commissioner's Review

Section 9 of the certificate requires approval for coverage of services from non-participating providers at the preferred level:

> Services you receive from Non-Participating Providers, unless those services were arranged by your PCP and approved in advance by us, or unless you need them to treat a Medical Emergency or Urgent Care situation, will be paid at the Alternate Benefits level. . . .

These Certificate requirements are common in managed care contracts. Priority Health is a health maintenance organization (HMO) that operates within a network of providers who sign contracts and agree to accept Priority Health's negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. A fundamental premise of an HMO is the centralization of health care delivery within its network of providers. If an HMO member uses an out-of-network provider when services from in-network providers are available, payment for the out-of-network services may be greatly reduced or even excluded entirely by the HMO.

The Petitioner states Priority Health applied Preferred Benefits coverage when he went to the XXXXX a few years ago and therefore does not understand why it cannot be applied in this case. Whatever prior claims experience the Petitioner had, the certificate is clear that services from non-participating providers, not approved in advance by Priority Health, will be paid at the Alternate Benefits level. The Commissioner finds Priority Health's determination of coverage at the Alternate Benefits level is consistent with the terms and conditions of the certificate.

V. ORDER

The Commissioner upholds Priority Health's May 26, 2011, final adverse determination. Priority Health is not required to provide Preferred Benefits coverage for Petitioner's treatment received at the XXXXX on March 21 and 22, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner